A Center Brief Report . . .

Mental Health of Children and Youth and the Role of Public Health Professionals

(January, 2004)

Those in the public health field are in a unique position to help promote the mental health of young people and reshape how the nation thinks about and addresses mental health. This brief highlights ways in which such professionals can join in the process of ensuring the impending transformation of the mental health system leads to better outcomes for all concerned.

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Mental Health of Children and Youth and the Role of Public Health Professionals

This brief report highlights the following:

- why mental health of children and youth is a major public health concern
- the importance of viewing causal factors from a broad perspective
- a continuum of intervention strategies for addressing the full range of problems
- some considerations related to mental health promotion
- some considerations related to prevention
- a note about screening for mental health problems
- the value of connecting with schools

Young People's Mental Health is a Major Public Health Concern

From NIMH's request for proposals on *Integrating Basic Behavioral Science and Public Mental Health*:

> Both the behavioral and public health sciences have a long, rich history in basic and applied research aimed at improving the lives of all Americans. These disciplines have complementary expertise.... Both disciplines have contributed to major improvements in our Nation's mental and medical health through advances in prevention and treatment. Even greater improvements can be achieved if behavioral and public health scientists increase their collaboration in areas of clearly shared interests....

Two specific areas of benefit cited are:

- understanding how social or other environmental contexts influence the etiology and prevention of mental illness
- examining risk and protective processes and developing conceptual models of new interventions

And, of course, the ultimate benefit of improving the mental health of children and youth, including reducing the numbers who experience mental health problems.

How many youngsters experience mental health problems?

As we have summarized in a recent report, data on diagnosable mental disorders suggest that from 12-22% of all youngsters under age 18 are in need of services for mental, emotional or behavioral problems (Center for Mental Health in Schools, 2003). These figures are

reflected in the Surgeon General's 1999 report on *Mental Health* (U.S. Department of Health and Human Services, 1999). Referring to ages 9 to 17, that document states that 21% or "one in five children and adolescents experiences the signs and symptoms of a DSM-IV disorder during the course of a year" – with 11% of all children experiencing significant impairment and about 5 percent experiencing "extreme functional impairment."

The picture worsens when one expands the focus beyond the limited perspective on diagnosable mental disorders to the number of young people experiencing psychosocial problems and who are "at risk of not maturing into responsible adults" (Dryfoos, 1990). Several reports have amply documented the problem (Greenberg, Domitrovich, & Bumbarger, 1999; IOM, 1994; NIMH, 1993, 1998; also see fact sheets and reports on the websites for the SAMHSA's Center for Mental Health Services and the USDOE's Safe and Drug Free Schools Program). For general purposes, it is sufficient to note the number of such youngsters in many schools serving low-income populations has climbed over the 50% mark, and few public schools have less than 20% who are at risk. An estimate from the Center for Demographic Policy suggests that 40% of young people are in bad educational shape and therefore will fail to fulfill their promise. The reality for many large urban schools is that well-over 50% of their students manifest significant learning, behavior, and emotional problems. For a large proportion of these youngsters, the problems are rooted in the restricted opportunities and difficult living conditions associated with poverty. All current policy discussions stress the crisis nature of the problem in terms of future health and economic implications for individuals and for society and call for major systemic reforms.

It is widely recognized that mental health is a fundamental and compelling societal concern. The relationship between health and mental health problems is well established. Health policy and practice call for health and mental health parity and for a greater focus on universal interventions to promote, prevent, and intervene as early after problem onset as is feasible.

So from both the perspective of promoting positive well-being and minimizing the scope of mental health and other health problems, it is clear that public health professionals have an important role to play.

This is underscored by the goals and recommendations formulated by the President's New Freedom Commission on Mental Health (2003). The Commission has delineated a significant role for public health professionals in helping transform the way the nation thinks about and addresses the mental health of young people. Of its six goals, goals 1, 3, 4, and 6 especially underscore efforts where major involvement of the public health system is a necessity.

- *Goal 1 seeks to enhance the understanding of Americans that mental health is essential to overall health.*

In this respect the Commission specifically calls for

> advancement and implementation of a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention

> addressing mental health with the same urgency as physical health

- *Goal 2 is concerned that mental health care is consumer and family driven.*

- *Goal 3 focuses on eliminating disparities in mental health services.*

The commission stresses the need to

> improve access to quality care that is culturally competent
> improve access to quality care in rural and geographically remote areas

- *Goal 4 seeks to make early mental health screening, assessment, and referral to services common practice.*

To these ends, the Commission calls for

> promoting the mental health of young children

> improving and expanding school mental health programs

> screening for co-occurring mental and substance use disorders and link with integrated treatment strategies

> screening for mental disorders in primary health care, across the lifespan, and connect to treatment and supports

- *Goal 5 calls for delivery of excellent mental health care and accelerated research*

- *Goal 6 calls for use of technology to access mental health care and information.*

What Causes Mental Health Problems?

Youngsters manifesting emotional upset, misbehavior, and learning problems commonly are assigned psychiatric labels that were created to categorize internal disorders. Thus, there is increasing use of terms such as attention deficit/hyperactivity disorder, depression, learning disabilities, and other specialized diagnostic terminology. This happens despite the fact that the problems of *most* youngsters are not rooted in internal pathology. Indeed, many of their troubling symptoms would not have developed if their environmental circumstances had been appropriately different.

Mental Health: What are we talking about?

There is a widespread tendency for the topic of mental health to be reduced to mental illness, disorders, or problems. When this occurs, mental health is de facto defined as the absence of these problems and there is a lack of emphasis on the enterprise of promoting positive social and emotional development for all.

To address this definitional problem, the following national reports are helpful:

- The report of the Surgeon General's Conference on Children's Mental Health (2001) vision statement: "Both the promotion of mental health in children and the treatment of mental disorders should be major public health goals." This statement uses the term mental health in ways that are consistent with definitional efforts to use mental health as a positive concept.

- The Institute of Medicine (1994) defines health as "state of well-being and the capability to function in the face of changing circumstance."

- A similar effort to contrast positive health with problem functioning is seen in SAMHSA's Center for Mental Health Services glossary of children's mental health terms. In that source, mental health is defined as "how a person thinks, feels, and acts when faced with life's situations.... This includes handling stress, relating to other people, and making decisions." SAMHSA contrasts this with mental health problems. And, the designation mental disorders is described as another term used for mental health problems. (They reserve the term mental illness for severe mental health problems in adults).

A more recent effort to emphasize mental health is found in *Bright Futures in Practice: Mental Health* (National Center for Education in Maternal and Child Health, 2002) which states: "Mentally healthy children and adolescents develop the ability to experience a range of emotions (including joy, connectedness, sadness, and anger) in appropriate and constructive ways: possess positive self-esteem and a respect for others; and harbor a deep sense of security and trust in themselves and the world. Mentally healthy children and adolescents are able to function in developmentally appropriate ways in the contexts of self, family, peers, school, and community. Building on a foundation of personal interaction and support, mentally healthy children and adolescents develop the ability to initiate and maintain meaningful relationships (love) and learn to function productively in the world (work)."

For most youngsters, psychopathology is not common; the majority experience psychosocial problems stemming from socio-cultural and economic factors

Another important definitional problem is the tendency to designate "everyday" emotional and behavioral problems as disorders (e.g., translating commonplace behavior into "symptoms" and formal psychiatric diagnoses). For children and adolescents, the most frequent problems are psychosocial, and the genesis of the problems for the majority are socio-cultural and economic. This, of course, in no way

denies that there are children for whom the primary factor instigating a problem is an internal disorder. The point simply recognizes that, comparatively, these youngsters constitute a relatively small group (see Center for Mental Health in Schools, 2003). Biases in definition overemphasizing this group narrow what is done to classify and assess problems, prevent problems, and intervene early after onset.

Diagnostic Labels Imply Person Pathology

Not surprisingly, debates about labeling young people tend to be heated. Differential diagnosis is difficult and fraught with complex issues (e.g., Adelman, 1995; Adelman & Taylor, 1994; Carnegie Council on Adolescent Development, 1989; Dryfoos, 1990). The thinking of those who study behavioral, emotional, and learning problems has long been dominated by models stressing person pathology. This is evident in discussions of cause, diagnosis, and intervention strategies. Because so much discussion focuses on person pathology, diagnostic systems have not been developed in ways that adequately account for psychosocial problems.

As a result, the prevailing comprehensive formal systems used to classify problems in human functioning convey the impression that all behavioral, emotional, or learning problems are instigated by internal pathology. This is well-illustrated by the widely-used Diagnostic and Statistical Manual of Mental Disorders – DSM IV (American Psychiatric Association, 1994). Some efforts to temper this trend frame pathology as a vulnerability that only becomes evident under stress. However, most differential diagnoses of children's problems are made by focusing on identifying one or more disorders (e.g., attention-deficit/hyperactivity disorder, oppositional defiant disorder, or adjustment disorders), rather than first asking: Is there a disorder?

Overemphasis on classifying problems in terms of personal pathology skews theory, research, practice, and public policy. One example is seen in the fact that comprehensive classification systems do not exist for environmentally caused problems or for psychosocial problems (caused by the transaction of internal and environmental factors).

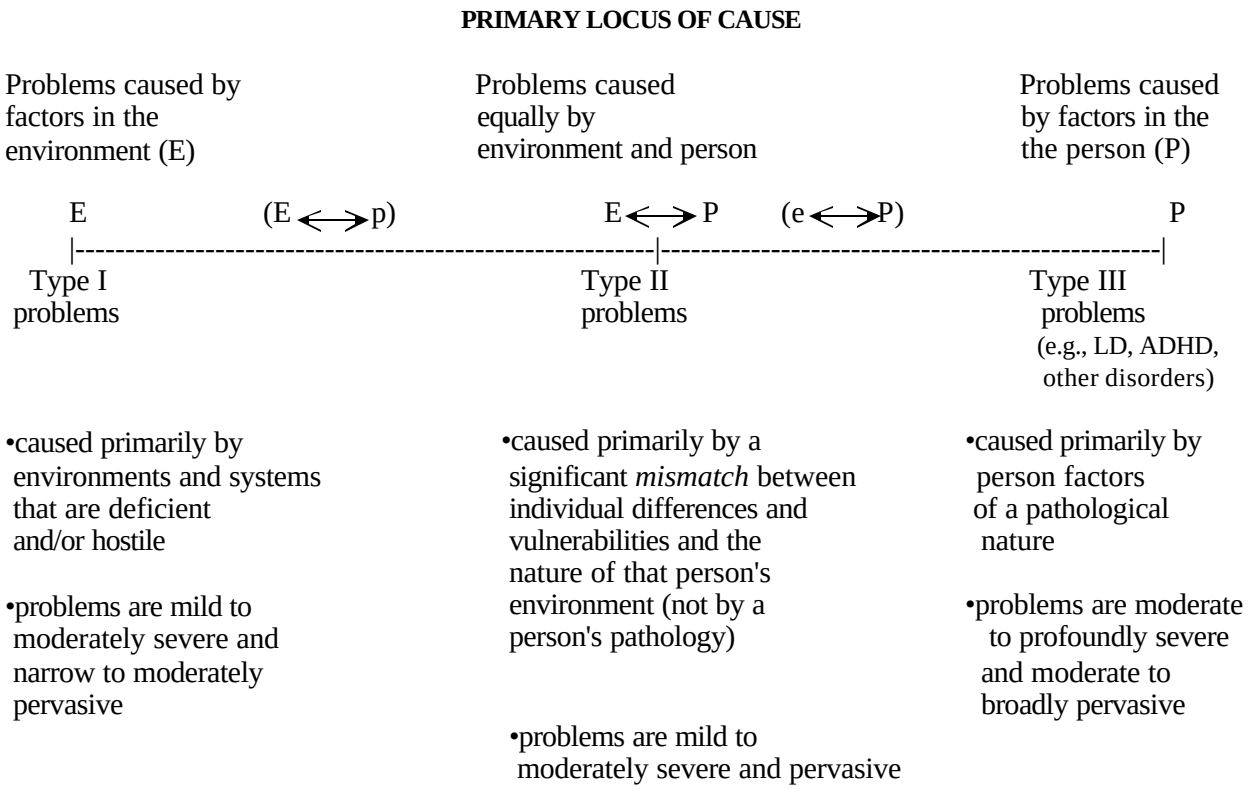
Understanding the Full Range of Causes

The need to address a wider range of variables in labeling problems is clearly seen in efforts to develop multifaceted systems. The American Academy of Pediatrics publishes *The Classification of Child and Adolescent Mental Diagnoses in Primary Care* – Diagnostic and Statistical Manual for Primary Care – DSM-PC (Wolraich, Felice, & Drotar,1996). This document provides a broad template for understanding and categorizing behavior. For each of the major categories, behaviors are described to illustrate what should be considered (a)a developmental variation, (b) a problem, and (c) a disorder (using DSM criteria).

Information is also provided on the environmental situations and stressors that exacerbate behavior and on commonly confused symptoms. The material is presented in a way that can be shared with families, so that they have a perspective with respect to concerns they or the school identifies.

The following conceptual example illustrates a broad framework that offers a useful starting place for classifying behavioral, emotional, and learning problems in ways that avoid overdiagnosing internal pathology. Such problems can be differentiated along a continuum that separates those caused by internal factors, environmental variables, or a combination of both (see Figure 1).

Figure 1. Problems Categorized on a Continuum Using a Transactional View of the Locus of Primary Instigating Factors*



* In this conceptual scheme, the emphasis in each case is on problems that are beyond the early stage of onset.

Problems caused by the environment are placed at one end of the continuum and referred to as Type I problems. At the other end are problems caused primarily by pathology within the person; these are designated as Type III problems. In the middle are problems stemming from a relatively equal contribution of environmental and person sources, labeled Type II problems.

To be more specific: In this scheme, diagnostic labels meant to identify extremely dysfunctional problems caused by pathological conditions within a person are reserved for individuals who fit the Type III category. At the other end of the continuum are individuals with problems arising from factors outside the person (i.e., Type I problems). Many people grow up in impoverished and hostile environmental circumstances. Such conditions should be considered first in hypothesizing what initially caused the individual's behavior,

emotional, and learning problems. (After environmental causes are ruled out, hypotheses about internal pathology become more viable.)

To provide a reference point in the middle of the continuum, a Type II category is used. This group consists of persons who do not function well in situations where their individual differences and minor vulnerabilities are poorly accommodated or are responded to hostilely. The problems of an individual in this group are a relatively equal product of person characteristics and failure of the environment to accommodate that individual.

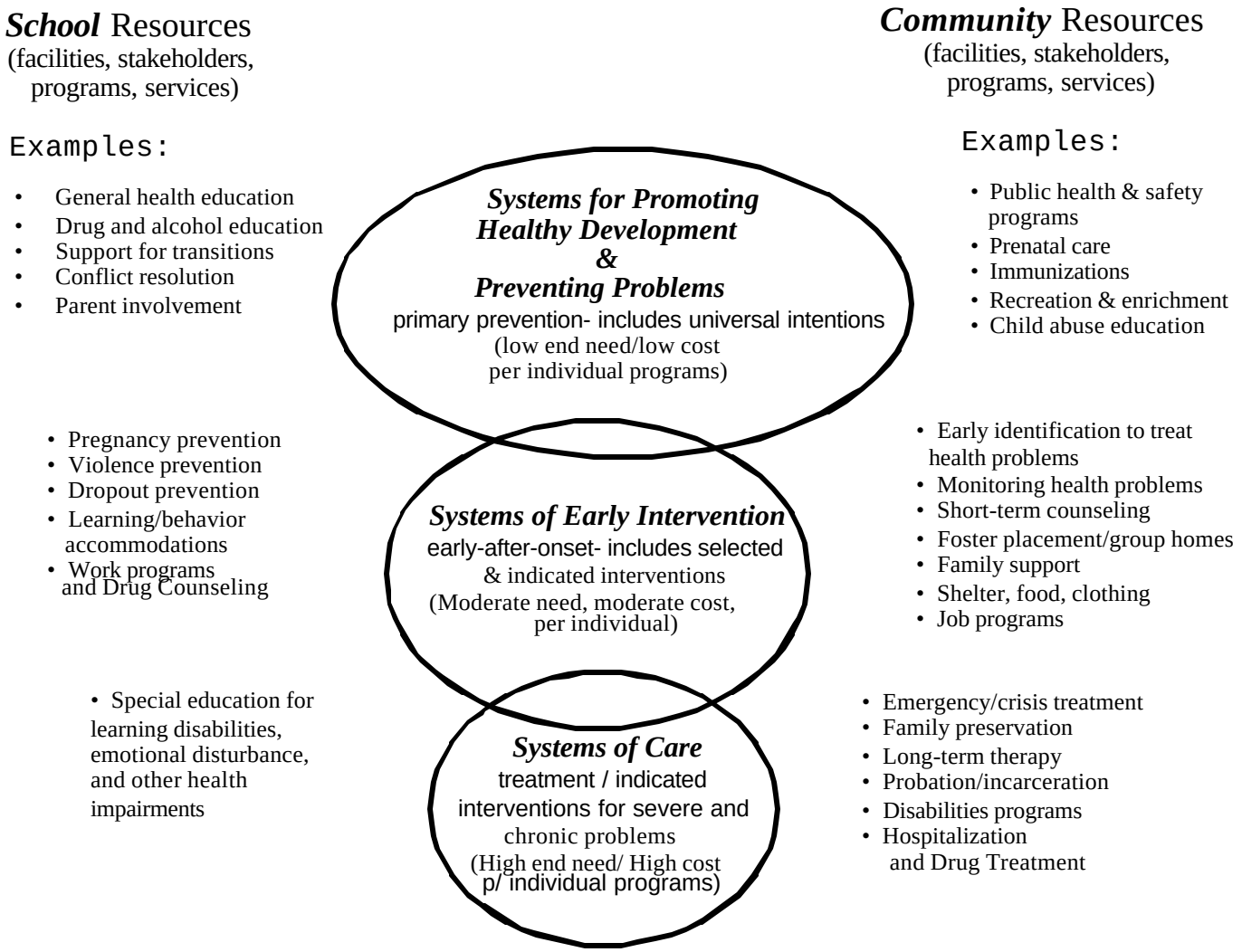
Clearly, a simple continuum cannot do justice to the complexities associated with labeling and differentiating psychopathology and psychosocial problems. Furthermore, some problems are not easily assessed or do not fall readily into a group due to data limitations and comorbidity. However, the above conceptual scheme shows the value of starting with a broad model of cause. In particular, it helps counter the tendency to jump prematurely to the conclusion that a problem is caused by deficiencies or pathology within the individual and thus can help combat the trend toward blaming the victim (Ryan, 1971). It also helps highlight the notion that improving the way the environment accommodates individual differences may be a sufficient intervention strategy.

Addressing the Full Range of Problems

When behavior, emotional, and learning problems are labeled in ways that overemphasize internal pathology, the helping strategies used primarily are some form of clinical/remedial intervention. For the most part, such interventions are developed and function in relative isolation of each other. Thus, they represent another instance of using piecemeal and fragmented strategies to address complex problems.

Ameliorating the full continuum of problems, illustrated above as Type I, II, and III problems, generally requires a comprehensive and integrated approach. To illustrate the range of programs needed to address Type I, II, and III problems, a framework outlining a continuum of systems of intervention is presented in Figure 2. The continuum ranges from systems for promoting healthy development and preventing problems (primary prevention) – through those for addressing problems soon after onset – on to treatments for severe and chronic problems. With respect to comprehensiveness, the range of programs highlights that many problems must be addressed develop-mentally and with a range of programs – some focused on individuals and some on environmental systems, some focused on mental health and some on physical health, education, and social services. With respect to concerns about integrating programs, the continuum underscores the need for concurrent interprogram linkages and for linkages over extended periods. The continuum emphasizes (1) public health protection, promotion, and maintenance that foster positive development and wellness, (2) preschool-age support and assistance to enhance health and psychosocial development, (3) early-schooling targeted interventions, (4) improvement and augmentation of ongoing regular support, (5) other interventions prior to referral for intensive and ongoing targeted treatments, and (6) intensive treatments (see Table 1).

Figure 2. Interconnected Systems for Meeting the Needs of All Children
*** Providing a Continuum of School-community Programs & Services**
*** Ensuring use of the LEAST INTERVENTION NEEDED**



Systemic collaboration** is essential to establish interprogram connections on a daily basis and over time to ensure seamless intervention within each system and among systems of prevention, systems of early intervention, and systems of care.

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* Such a collaboration involves horizontal and vertical restructuring of programs and services
(a) within jurisdictions, school districts, and community agencies (e.g., among departments, divisions, units, schools, clusters of schools)
(b) between jurisdictions, school and community agencies, public and private sectors; among schools; among community agencies

Table 1. From primary prevention to treatment of serious problems: A continuum of community-school programs to address barriers to learning and enhance healthy development

Intervention Continuum	***Examples of Focus and Types of Intervention*** (Programs and services aimed at system changes and individual needs)
Systems for Health Promotion & Primary prevention	*1. Public health protection, promotion, and maintenance to foster opportunities, positive development, and wellness* • economic enhancement of those living in poverty (e.g., work/welfare programs) • safety (e.g., instruction, regulations, lead abatement programs) • physical and mental health (incl. healthy start initiatives, immunizations, dental care, substance abuse prevention, violence prevention, health/mental health education, sex education and family planning, recreation, social services to access basic living resources, and so forth)
Systems for Early-after-problem onset intervention	*2. Preschool-age support and assistance to enhance health and psychosocial development* • systems' enhancement through multidisciplinary team work, consultation, and staff development • education and social support for parents of preschoolers • quality day care • quality early education • appropriate screening and amelioration of physical and mental health and psychosocial problems
	3. Early-schooling targeted interventions • orientations, welcoming and transition support into school and community life for students and their families (especially immigrants) • support and guidance to ameliorate school adjustment problems • personalized instruction in the primary grades • additional support to address specific learning problems • parent involvement in problem solving • comprehensive and accessible psychosocial and physical and mental health programs (incl. a focus on community and home violence and other problems identified through community needs assessment)
	4. Improvement and augmentation of ongoing regular support • enhance systems through multidisciplinary team work, consultation, and staff development • preparation and support for school and life transitions • teaching "basics" of support and remediation to regular teachers (incl. use of available resource personnel, peer and volunteer support) • parent involvement in problem solving • resource support for parents-in-need (incl. assistance in finding work, legal aid, ESL and citizenship classes, and so forth) • comprehensive and accessible psychosocial and physical and mental health interventions (incl. health and physical education, recreation, violence reduction programs, and so forth) • Academic guidance and assistance • Emergency and crisis prevention and response mechanisms
	5. Other interventions prior to referral for intensive, ongoing targeted treatments • enhance systems through multidisciplinary team work, consultation, and staff development • short-term specialized interventions (including resource teacher instruction and family mobilization; programs for suicide prevention, pregnant minors, substance abusers, gang members, and other potential dropouts)
Systems for Treatment for severe/chronic problems	*6. Intensive treatments* • referral, triage, placement guidance and assistance, case management, and resource coordination • family preservation programs and services • special education and rehabilitation • dropout recovery and follow-up support • services for severe-chronic psychosocial/mental/physical health problems

Promoting Mental Health

If the only response to a family's concerns is to diagnose a disorder, large numbers of misdiagnoses are inevitable and the response to problems often will be inappropriate and expensive. Furthermore, the amount of misdiagnoses will continue as a major contaminate in research and training. The way to reduce misdiagnoses and misprescriptions is to place mental illness in perspective with respect to psychosocial problems and to broaden the definition of mental health to encompass the promotion of social and emotional development and learning. For the most effective interventions, mental health must be seen as both

a) promoting healthy development as one of the keys to preventing mental health and psychosocial problems, and

b) a comprehensive focus on addressing barriers to development and learning. This requires interventions that

- directly facilitate physical, social and emotional development
- innoculate against mental health and psychosocial problems,
- identify, correct, or at least minimize problems as early after their onset as is feasible
- provide for coordinated treatment of severe and chronic problems.

While screening and diagnosing problems and providing clinical services are fundamental to any mental health system, just identifying problems is insufficient. Also required are interventions that assist youngsters and their support systems to acquire knowledge, skills, and attitudes that enable them to prevent problems and deal with those that can't be avoided.

In pursuing intervention, current policy and practice agendas also stress that it is essential to

- *achieve results*
- *involve and mobilize consumers and enhance partnerships with those at home, at school, and in the community*
- *confront equity and human diversity considerations*
- *balance the focus on addressing problems with an emphasis on promoting health and development of assets*
- *include evidence-based strategies.*

A broad intervention framework for mental health intervention builds on the broadest definitions discussed above and focuses on working with youngsters, families, schools, and communities. As already

Promotion interventions encompass efforts to enhance knowledge, skills, and attitudes to foster social and emotional development, a healthy life-style, and personal well-being.

indicated, this encompasses interventions to promote, prevent, and intervene as early after problem onset as is feasible, as well as involvement with severe and chronic problems.

Promoting healthy development, well-being, and a value-based life are important ends unto themselves and are keys to preventing mental health and psychosocial problems. Such interventions focus not only on strengthening individuals, but also on enhancing nurturing and supportive conditions at school, at home, and in the neighborhood. All this includes a particular emphasis on increasing opportunities for personal development and empowerment by promoting conditions that foster and strengthen positive attitudes and behaviors (e.g., enhancing motivation and capability to pursue positive goals, resist negative influences, and overcome barriers).

Prevention

As indicated above promoting healthy development is one facet of prevention. Other facets involve addressing *risk factors* and enhancing *protective buffer*s. Again, the intervention focus not only is on individuals, but on conditions at home, in the neighborhood, and at school. It is well to remember that research indicates that the primary causes for most youngsters' emotional, behavior, and learning problems are external factors (e.g., related to neighborhood, family, school, and/or peer factors such as extreme economic deprivation, community disorganization, high levels of mobility, violence, drugs, poor quality or abusive caretaking, poor quality schools. negative encounters with peers, inappropriate peer models, immigrant status). For a few, problems stem from individual disorders and differences (e.g., medical problems, low birth weight/neurodevelopmental delay, psychophysiological problems, difficult temperament and adjustment problems). For more on this see

> *A Good Beginning: Sending America's Children to School with the Social and Emotional Competence They Need to Succeed* – http://www.nimh.nih.gov/childp/prfan.cfm.

Protective factors are conditions that *buffer* against risk factors. Such conditions may prevent or counter risk producing conditions by fostering individual, neighborhood, family, school, and/or peer strengths, assets, and coping mechanisms. The intervention focus is on developing special relationships and providing special assistance and accommodations. The term *resilience* usually refers to an individual's ability to cope in ways that buffer.

While prevention encompasses efforts to promote well-being, the primary focus is on interventions to reduce risks and enhance buffers either through programs designed for the general population (often referred to as universal interventions) or for selected groups designated at risk.

Public health professionals can encourage youngsters and their families to take advantage of opportunities in the schools and community to prevent problems and enhance protective buffers (e.g.,resilience). Examples include enrollment in

- direct instruction designed to enhance specific areas of knowledge, skills, and attitudes on mental health matters

- enrichment programs and service learning opportunities at school and/or in the community

- after school youth development programs

In addition, public health professionals have a role to play in public health initiatives designed to strengthen families and communities. For examples the National Strategy for Suicide Prevention (http://www.mentalhealth.org/publications/allpubs/SMA01-3518/index.htm) has as it's first goal promote awareness that suicide is a public health problem that is preventable and suggesting developing public education campaigns, sponsoring national conferences on suicide prevention, organizing special-issue forum, and disseminating information

A Note About Mental Health Screening

Each year a great many parents and teachers identify large numbers of children (e.g., of kindergarten age) soon after the onset of a problem. This natural screening can be helpful in initiating supportive accommodations that can be incorporated into regular school and home practice. By addressing these problems through "response to intervention" many will receive the support needed to overcome the problems. Those who do not respond to these early interventions can be further assessed and appropriately treated.

Formal screening to identify students who have problems or who are "at risk" is accomplished through individual or group procedures. Most such procedures are *first-level* screens and are expected to over-identify problems. That is, they identify many students who do not really have significant problems (false positive errors). This certainly is the case for screens used with infants and primary grade children, but false positives are not uncommon when adolescents are screened. Errors are supposed to be detected by follow-up assessments. Because of the frequency of false positive errors, serious concerns arise when screening data are used to diagnose students and prescribe remediation and special treatment. Screening data primarily are meant to sensitize responsible professionals. No one wants to ignore indicators of significant problems. At the same time, there is a need to guard against tendencies to see *normal variations* in students' development and behavior and other facets of human diversity as problems. First level screens do not allow for definitive statements about a student's problems and need. At best, most such screening procedures provide a preliminary indication that something may be wrong. In considering formal diagnosis and prescriptions for how to correct the problem, one needs data from assessment procedures that have greater validity. It is essential to remember that many factors found to be symptoms of problems also are common characteristics of young people, especially in adolescence.

This means extreme caution must be exercised to avoid misidentifying and appropriately stigmatizing a youngster. It is easy to overestimate the significance of a few indicators.

Connecting with Schools

Schools potentially are a major public health resource (Blum, McNeely, & Rinehart, 2002). They can offer a range of programs and services designed to promote healthy development, prevent problems, and provide support and follow up when there is an early indication of problems (see Appendix).

Public health professionals need to enhance collaborative relationships with schools. School staff and public health professionals share goals related to education and socialization of the young. Ultimately, they must collaborate with each other if they are to accomplish their respective missions.

One of the most important, cross-cutting social policy perspectives to emerge in recent years is an awareness that no single institution can create all the conditions that young people need to flourish . . . .

Melaville & Blank, 1998

Promoting well-being, resilience, and protective factors and empowering families, communities, and schools all requires multiple and interrelated interventions and the concerted effort of all stakeholders. Leaving no child behind is only feasible through well-designed collaborative efforts.

Properly done, collaboration with schools should strengthen families and neighborhoods, improve schools, and lead to a marked reduction in young people's problems. However, while it is relatively simple to make informal linkages, establishing major long-term collaborations is complicated. Doing so requires vision, cohesive policy, and basic systemic reforms. The complications are readily seen in any effort to develop a full continuum of interventions as illustrated in Figure 1. Major systemic changes are required to develop and evolve formal and institutionalized sharing of a wide spectrum of responsibilities and resources (see Adelman & Taylor, 2003; Center for Mental Health in Schools, 2002).

Obviously, true collaboration involves more than meeting and talking. The point is to work together in ways that produce the type of actions that result in important results. For this to happen, steps must be taken to ensure that collaboratives are formed in ways that ensure they can be effective. This includes providing them with the training, time, support, and authority to carry out their roles and functions. It is when such matters are ignored that groups find themselves meeting and meeting, but going nowhere.

It is commonly said that collaboratives are about building relationships. It is important to understand that the aim is to build potent, synergistic, *working* relationships, not simply to establish positive personal connections. Collaboratives built mainly on personal connections are vulnerable to the mobility that characterizes many such groups. The point is to establish stable and sustainable working relationships. This requires clear roles, responsibilities, and an institutionalized infrastructure, including well-designed mechanisms for performing tasks, solving problems, and mediating conflict.

Through collaboration with schools, public health professionals can help build the continuum of interventions needed to make a significant impact in addressing the safety, health, learning, and general well being of all youngsters through strengthening youngsters, families, schools, and neighborhoods.

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Appendix

What Schools Do Related to Mental Health

It is, of course, not a new insight that psychosocial and mental health concerns must be addressed if schools are to function satisfactorily and students are to learn and perform effectively. It has long been acknowledged that a variety of such problems affect learning in profound ways. Moreover, these problems are exacerbated as youngsters internalize the debilitating effects of performing poorly at school and are punished for the misbehavior that is a common correlate of school failure. Because of this, school policy makers, have a lengthy, albeit somewhat reluctant, history of trying to assist teachers in dealing with problems that interfere with schooling.

Currently, there are about 90,000 public schools in about 15,000 districts. Over the years, most (but obviously not all) schools have instituted policies and programs designed with a range of mental health and psychosocial concerns in mind. Some directly support school counseling, psychological, and social service programs and personnel; others connect community programs and personnel with schools. As a result, most schools have some programs to address a range of mental health and psychosocial concerns, such as school adjustment and attendance problems, substance abuse, emotional problems, relationship difficulties, violence, physical and sexual abuse, delinquency, and dropouts. And, there is a large body of research supporting the promise of much of this activity.[1]

School-based and school-linked programs have been developed for purposes of early intervention, crisis intervention and prevention, treatment, and promotion of positive social and emotional development. Some programs are provided throughout a district, others are carried out at or linked to targeted schools. The interventions may be offered to all students in a school, to those in specified grades, or to those identified as "at risk." The activities may be implemented in regular or special education classrooms or as out of classroom programs and may be designed for an entire class, groups, or individuals. There also may be a focus on primary prevention and enhancement of healthy development through use of health education, health services, guidance, and so forth – though relatively few resources usually are allocated for such activity. (See the next page for an Exhibit highlighting five major *delivery mechanisms and formats*).

School districts use a variety of their own *personnel* to address student support concerns. These may include "pupil services" or "support services" specialists such as psychologists, counselors, social workers, psychiatrists, and nurses, as well as a variety of related therapists. Such specialists tend to focus on students seen as problems or as having problems. Their many *functions* can be grouped into three categories (1) direct services and instruction, (2) coordination, development, and leadership related to programs, services, resources, and systems, and (3) enhancement of connections with community resources. Despite the range of activity, it remains the case that too little is being done in most schools, and prevailing approaches are poorly conceived and are implemented in fragmented ways.

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[1]For relevant references, go to
(1) http://smhp.psych.ucla.edu/qf/references.htm
(2) http://smhp.psych.ucla.edu/pdfdocs/briefs/BarriersBrief.pdf
(3) http://smhp.psych.ucla.edu/pdfdocs/aboutmh/annotatedlist.pdf
(4) http://smhp.psych.ucla.edu/pdfdocs/policymakers/cadreguidelines.pdf
(5) http://www.nationalguidelines.org/

Exhibit: Delivery Mechanisms and Formats for MH in Schools

The five mechanisms and related formats are:

1. ***School-Financed Student Support Services*** – Most school districts employ pupil services professionals such as school psychologists, counselors, school nurses, and social workers to perform services related to mental health and psychosocial problems (including related services designated for special education students). The format for this delivery mechanism tends to be a combination of centrally-based and school-based services.

2. ***School-District Mental Health Unit*** – A few districts operate specific mental health units that encompass clinic facilities, as well as providing services and consultation to schools. Some others have started financing their own School-Based Health Centers with mental health services as a major element. The format for this mechanism tends to be centralized clinics with the capability for outreach to schools.

3. ***Formal Connections with Community Mental Health Services*** – Increasingly, schools have developed connections with community agencies, often as the result of the school-based health center movement, school-linked services initiatives (e.g., full service schools, family resource centers), and efforts to develop systems of care ("wrap-around" services for those in special education). Four formats and combinations thereof have emerged:

    - co-location of community agency personnel and services at schools – sometimes in the context of School-Based Health Centers partly financed by community health organizations
    - formal linkages with agencies to enhance access and service coordination for students and families at the agency, at a nearby satellite clinic, or in a school-based or linked family resource center
    - formal partnerships between a school district and community agencies to establish or expand school-based or linked facilities that include provision of MH services
    - contracting with community providers to provide needed student services

4. ***Classroom-Based Curriculum and Special Out of Classroom Interventions*** – Most schools include in some facet of their curriculum a focus on enhancing social and emotional functioning. Specific instructional activities may be designed to promote healthy social and emotional development and/or prevent psychosocial problems such as behavior and emotional problems, school violence, and drug abuse. And, of course, special education classrooms always are supposed to have a constant focus on mental health concerns. Three formats have emerged:

    - integrated instruction as part of the regular classroom content and processes
    - specific curriculum or special intervention implemented by personnel specially trained to carry out the processes
    - curriculum approach is part of a multifaceted set of interventions designed to enhance positive development and prevent problems

5. ***Comprehensive, Multifaceted, and Integrated Approaches*** – A few school districts have begun the process of reconceptualizing their piecemeal and fragmented approaches to addressing barriers that interfere with students having an equal opportunity to succeed at school. They are starting to restructure their student support services and weave them together with community resources and integrate all this with instructional efforts that effect healthy development. The intent is to develop a full continuum of programs and services encompassing efforts to promote positive development, prevent problems, respond as early-after-onset as is feasible, and offer treatment regimens. Mental health and psychosocial concerns are a major focus of the continuum of interventions. Efforts to move toward comprehensive, multifaceted approaches are likely to be enhanced by initiatives to integrate schools more fully into systems of care and the growing movement to create community schools. Three formats are emerging:

    - mechanisms to coordinate and integrate school and community services
    - initiatives to restructure student support programs and services and integrate them into school reform agendas
    - community schools

There are a number of resources available that feature evidence based strategies for strengthening schools support for students The following table provides a list of lists, with indications of what each list covers, how it was developed, what it contains, and how to access it.

Annotated "Lists" of Empirically Supported/evidence Based Interventions For School-aged Children And Adolescents

I. Universal Focus on Promoting Healthy Development

A. ***Safe and Sound. An Educational Leader's Guide to Evidence-Based Social & Emotional Learning Programs*** (2002). The Collaborative for Academic, Social, and Emotional Learning (CASEL).

1. *How it was developed:* Contacts with researchers and literature search yielded 250 programs for screening; 81 programs were identified that met the criteria of being a multiyear program with at least 8 lessons in one program year, designed for regular ed classrooms, and nationally available.

2. *What the list contains:* Descriptions (purpose, features, results) of the 81 programs.

3. *How to access:* CASEL (http://www.casel.org)

B. ***Positive Youth Development in the United States: Research Findings on Evaluations of Positive Youth Development Programs*** *(2002).* Social Develop. Res. Group, Univ. of Wash.

1. *How it was developed:* 77 programs that sought to achieve positive youth development objectives were reviewed. Criteria used: research designs employed control or comparison group and had measured youth behavior outcomes.

2. *What the list contains:* 25 programs designated as effective based on available evidence.

3. *How to access:* Online journal *Prevention & Treatment* (http://journals.apa.org/prevention/volume5/pre0050015a.html)

II. Prevention of Problems; Promotion of Protective Factors

A. ***Blueprints for Violence Prevention*** (1998). Center for the Study and Prevention of Violence, Institute of Behavioral Science, University Colorado, Boulder.

1. *How it was developed:* Review of over 450 delinquency, drug, and violence prevention programs based on a criteria of a strong research design, evidence of significant deterrence effects, multiple site replication, sustained effects.

2. *What the list contains: 10* model programs and 15 promising programs.

3. *How to access:* Center for the Study and Prevention of Violence (http://www.colorado.edu/cspvblueprints/model/overview.html)

B. ***Exemplary Substance Abuse Prevention Programs*** (2001). Center for Substance Abuse Prevention (SAMHSA).

1. *How it was developed:* (a) Model Programs: implemented under scientifically rigorous conditions and demonstrating consistently positive results. These science-based programs underwent an expert consensus review of published and unpublished materials on 15 criteria (theory, fidelity, evaluation, sampling, attrition, outcome measures, missing data, outcome data, analysis, threats to validity, integrity, utility, replications, dissemination, cultural/age appropriateness. (b) Promising Programs: those that have positive initial results but have yet to verify outcomes scientifically.

2. *What the list contains*: 30 substance abuse prevention programs that may be adapted and replicated by communities.

3. *How to access:* SAMHSA (http://www.modelprograms.samhsa.gov)

C. ***Preventing Drug Use Among Children & Adolescents. Research Based Guide*** (1997). National Institute on Drug Abuse (NIDA).

1. *How it was developed:* NIDA and the scientists who conducted the research developed research protocols. Each was tested in a family/school/community setting for a reasonable period with positive results.

2. *What the list contains:* 10 programs that are universal, selective, or indicated.

3. *How to access:* NIDA (www.nida.nih.gov/prevention/prevopen.html)

D. ***Safe, Disciplined, and Drug-Free Schools Expert Panel Exemplary Programs*** (2001). U.S. Dept. of Educ. Safe & Drug Free Schools

1. *How it was developed:* Review of *132* programs submitted to the panel. Each program reviewed in terms of quality, usefulness to others, and educational significance.

2. *What the list contains:* 9 exemplary and *33* promising programs focusing on violence, alcohol, tobacco, and drug prevention.

3. *How to access*: U.S. Dept. of Education – (http://www.ed.gov/offices/OERI/ORAD/KAD/expert_panel/drug-free.html)

III. Early Intervention: Targeted Focus on Specific Problems or at Risk Groups

A. ***The Prevention of Mental Disorders in School-Aged Children: Current State of the Field*** (2001). Prevention Research Center for the Promotion of Human Development, Pennsylvania State University.

1. *How it was developed:* Review of scores of primary prevention programs to identify those with quasi-experimental or random-ized trials and been found to reduce symptoms of psychopathology or factors commonly associated with an increased risk for later mental disorders.

2. *What the list contains:* 34 universal and targeted interventions that have demonstrated positive outcomes under rigorous evaluation and the common characteristics of these programs.

3. *How to access:* Online journal *Prevention & Treatment* http://journals.apa.org/prevention/volume4/pre0040001a.html

IV. Treatment for Problems

A. ***The American Psychological Association, Division of Child Clinical Psychology, Ad Hoc Committee on Evidence-Based Assessment and Treatment of Childhood Disorders,*** published it's initial work as a special section of the *Journal of Clinical Child Psychology* in 1998.

1. *How it was developed:* Reviewed outcomes studies in each of the above areas and examined how well a study conforms to the guidelines of the Task Force on Promotion and Dissemination of Psychological Procedures (1996).

2. *What it contains:* reviews of anxiety, depression, conduct disorders, ADHD, broad spectrum Autism interventions, as well as more global review of the field. For example:
   - >*Depression:* results of this analysis indicate only 2 series of studies meet criteria for probably efficacious interventions and no studies meet criteria for well-established treatment.
   - >*Conduct disorder:* Two interventions meet criteria for well established treatments: videotape modeling parent training programs (Webster-Stratton) and parent training program based on Living with Children (Patterson and Guillion). Twenty additional studies identified as probably efficacious.
   - >Attention Deficit Hyperactivity Disorder: behavioral parent training and behavioral interventions in the classroom meet criteria for well established treatments. Cognitive interventions do not meet criteria for well-established or probably efficacious treatments.
   - >Phobia and Anxiety: for phobias participant modeling and reinforced practice are well established; filmed modeling, live modeling, and cognitive behavioral interventions that use self instruction training are probably efficacious. For anxiety disorders, only cognitive-behavioral procedures with and without family anxiety management were found to be probably efficacious.

Caution: Reviewers stress the importance of devising developmentally and culturally sensitive interventions targeted to the unique needs of each child; need for research that is informed by clinical practice.

3. *How it can be accessed*: APA *Journal of Clinical Child Psychology* (1998) v.27, pp. 156-205.

V. Review/Consensus Statements/ Compendia of Evidence Based Treatments

A. ***School-Based Prevention Programs for Children & Adolescents*** (1995). J.A. Durlak. Sage: Thousand Oaks, CA. Reports results from 130 controlled outcome studies that support "a secondary prevention model emphasizing timely intervention for subclinical problems detected early.... In general, best results are obtained for cognitive-behavioral and behavioral treatments & interventions targeting externalizing problems."

B. ***Mental Health and Mass Violence:*** Evidence-based early psychological intervention for victims/ survivors of mass violence. A workshop to reach consensus on best practices (U.S. Departments of HHS, Defense, Veterans Affairs, Justice, and American Red Cross). Available at: (http://www.nimh.nih.gov/research/massviolence.pdf)

C. ***Society of Pediatric Psychology***, Division 54, American Psychological Association, *Journal of Pediatric Psychology*. Articles on empirically supported treatments in pediatric psychology related to obesity, feeding problems, headaches, pain, bedtime refusal, enuresis, encopresis, and symptoms of asthma, diabetes, and cancer.

D. ***Preventing Crime: What works, what doesn't, what's promising. A Report to the United States Congress*** (1997) by L.W. Sherman, Denise Gottfredson, et al. Washington, DC: U.S. Dept. of Justice. Reviews programs funded by the OJP for crime, delinquency and substance use. (http://www.ncjrs.org/pdffiles/171676.pdf). Also see Denise Gottfredson's book: *Schools and delinquency* (2001). New York: Cambridge Press.

E. School Violence Prevention Initiative Matrix of Evidence-Based Prevention Interventions (1999). Center for Mental Health Services SAMHSA. Provides a synthesis of several lists cited above to highlight examples of programs which meet some criteria for a designation of evidence based for violence prevention and substance abuse prevention. (i.e., Synthesizes lists from the Center for the Study and Prevention of Violence, Center for Substance Abuse Prevention, Communities that Care, Dept. of Education, Department of Justice, Health Resources and Services Administration, National Assoc. of School Psychologists) http://modelprograms.samhsa.gov/matrix_all.cfm